SCC Health Science Student Health Record

The purpose of the SCC Health Science Student Health Record is to

1) Provide evidence to your statement that you meet the technical standards of your health science program
2) Provide a medical history form in case of an emergency while in the clinical setting
3) Provide medical information regarding prior medical history for clinical sites in case of infectious outbreak or clinical incident.

This form will be kept securely in a medical document manager or the files of the SCC program or clinical coordinator and not shared unless there is a need to know.
You will need an appointment with a healthcare provider to complete this form.
If you have questions while completing this form, contact your program clinical coordinator.

Instructions:
#1 Please print in ink or type Section A before going to your provider for examination. Be sure to answer all questions fully and include your name at the top of each page. Health information, including immunization records will be released to authorized clinical agencies.

#2 Students must submit the completed "Student Health Record" prior to program progression.

#3 Students will receive clearance for clinical with a complete and approved record. Program may require additional pre-clinical documentation.

Student Resources provided by SCC
If you have questions concerning accessibility, disability, or if you are requesting reasonable accommodations at SCC, please contact the Office of Learner Accessibility & Equity at accessibility@southwesterncc.edu or 828.339.4326. To learn more about the accommodation process and requirements at SCC, visit https://www.southwesterncc.edu/accessibility.

If you have questions about accessing mental health services at SCC at no cost to you, contact our counselor, _____ or 828-339-4243

Student Name & ID:_____

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SECTION A: Student to complete.

Student Name:	(last)		(first)		(middle)	

Birthdate:		**Phone number:**	

Mailing Address: *Include street, city, state and zipcode*	

Student Email:		**Intended Health Science Major**	

If any are positive (yes) please explain below.

Have you had? CHECK Yes or NO	Yes	No	**Have you had? CHECK Yes or NO**	Yes	No
Rubeola			Recurrent headaches		
Rubella			Vision or eye problems		
Mumps			Insomnia or Trouble staying awake		
Chicken pox (MD documented)			Epilepsy/Convulsions		
Infectious Mono			Fainting		
Positive TB Skin Test			Hay fever or allergies		
Hepatitis (specify: A,B,C,D,E)			Ear or sinus problems		
Rheumatic fever			Asthma or other lung problems		
Other infectious diseases?			Diabetes or unstable blood sugars		
Back or neck problems			Stomach/Intestinal problems		
Arthritis or joint problems			Kidney/Bladder problems		
Muscle pain, problems or weakness			Heart murmurs		
Color blindness			Mitral Valve Prolapse		
Worry or Nervousness			High blood pressure		
Anxiety			Irregular heart beat(pulse) including too high or low		
Depression			Recurrent Herpes Virus outbreak (eg: cold sores, etc)		

Student Name & ID:_____

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Ongoing mental health condition			Sexually Transmitted Disease		
Alcohol or substance use dependency			Organ transplant		
Nicotine dependency: Type:			Other (explain below):		

If you marked yes to any medical questions in the previous section, please give further information on dates, times, current situation and treatment:_____

_____

_____

Current medications

Include prescription, over the counter, herbal and supplemental preparations

DRUG OR FOOD ALLERGIES:_____

Medication (herb, vitamin or supplement)	Dose or amount	How often or when	Reason for taking	Other relevant information (eg, causes sleepiness)

By signing this form, I agree this is truthful to the best of my knowledge and indicates I meet the **technical requirements** of my intended health science major. I understand I may request reasonable accommodations and have been provided the contact information to further discuss my needs. I also understand I am giving consent for clinical agencies and program or clinical coordinators to access my medical information on a need to know basis for entry and passage through my intended health science program.

_____ _____

Signature (in ink, your handwriting) Date

_____

Print or typed name

Student Name & ID:_____

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Section B: To be completed by a healthcare provider (Physician, Physician Assistant or Nurse Practitioner)

Instructions:

1. Review the information provided by the student in Section A.
2. Complete Section B based on the current assessment.
3. Provide student with the required immunization records, immunizations or titers, and if required 2 step TB test (T spot accepted; CXR for +TB), or a referral to a clinic where these can be obtained.

Height: _____ Weight:_____ Pain score:_____

Pulse: _____ Respirations: _____Temp:_____Blood pressure: _____

Corrected Vision: LEFT: 20/ RIGHT: 20/

Hearing: (Please circle) LEFT: Normal or Impaired RIGHT: Normal or Impaired

_____

1. Does the student have any concerns or new findings in the following systems? (Give dates, description of change, and treatment of ALL findings - see below)

System	Yes	No	System	Yes	No
Sensory			Gastrointestinal		
Psychiatric and Neurocognitive			Genitourinary		
Eyes			Skin		
Ears, Nose, throat			Musculoskeletal		
Neurological			Endocrine/Metabolic		
Respiratory			Immune		
Cardiovascular (include murmurs)			Other (please explain)		

2. If you have answered "yes" to any item in **(1)** above, please complete the following: (Additional information may be provided on a separate page identified with student's full name).

Date	Diagnosis	Treatment	Restrictions/Limitations (Bending, lifting, pulling, etc.)

3. Was this exam completed by verbal assessment _____ or by physical assessment?_____

4. A mental health screening completed today?_____ Yes or _____No

_____ _____ _____

Healthcare Provider Signature & credentials Printed Name Date

Student Name & ID:_____